Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

www.dmas.virginia.gov

MEDICAID MEMO

TO: Providers of Treatment Foster Care Case Management

FROM: Patrick W. Finnerty, Director
Department of Medical Assistance Services

DATE: 1/31/2007

SUBJECT: Changes to Treatment Foster Care Case Management Reimbursement – Effective March 1, 2007

The purpose of this memo is to provide information on changes in reimbursement of Treatment Foster Care Case Management (TFC-CM) required by the Deficit Reduction Act (DRA) of 2005 to be effective March 1, 2007. DMAS, the Office of Comprehensive Services (OCS), and the Department of Social Services (DSS) are working together to implement the changes as smoothly as possible to minimize the burden on private providers and localities.

Federally Mandated Changes – Covered and Non-Covered Services

The Deficit Reduction Act (DRA) requires DMAS to limit Medicaid reimbursement for treatment foster care case management services. Although case management services are still permitted by the DRA, the definition has been narrowed. Section 1396n(g)(2) of the DRA defines case management as "services which will assist Medicaid eligible individuals in gaining access to needed medical, social, educational, and other services." The DRA identifies covered services as:

- Assessment
- Development of a specific plan of care
- Referral to assist the individual to obtain needed services by linking them to medical, social, educational services
- Monitoring and follow up

Non-Covered Services

The DRA definition of case management specifically excludes certain services. Medicaid cannot reimburse for the direct delivery of a medical, educational, social, or other service by the case manager. The DRA identifies specific foster care services that cannot be paid by Medicaid. They are:

- Research gathering and completion of documentation required by the foster care program
- Assessing adoption placements

- Recruiting or interviewing potential foster care parents
- Serving legal papers
- Home investigations
- Providing transportation
- Administering foster care subsidies
- Making placement arrangements

Additionally, the DRA states that Medicaid cannot reimburse for case management services if there are other third parties liable to pay for such services, including medical, social, educational, or other programs. The Centers for Medicare and Medicaid Services (CMS) has stated that if Title IV-E can pay for the service, then Medicaid cannot reimburse for that service.

Reimbursement Changes

To ensure compliance with the DRA, DMAS is implementing changes to Treatment Foster Care Case Management effective March 1, 2007. As of this date, **only** the DRA approved functions of assessment, development of a specific plan of care, referral, monitoring and follow up may be reimbursed by Medicaid. All other services will be considered non-covered. Providers may continue to bill Medicaid for the DMAS allowed TFC-CM activities and will be reimbursed up to the Medicaid maximum rate of $326.50 per month for services rendered on or after March 1, 2007. The service will be billed as one unit per month. Prior authorization (PA) continues to be required. Further clarification on any changes to the PA process will be provided in the monthly Medicaid memos and in the upcoming, revised Medicaid Psychiatric Services Manual.

Specific information details on TFC-CM requirements can be found in the Medicaid Psychiatric Services Manual available on the DMAS website (www.dmas.virginia.gov) and in the KePRO Provider Manual, available at https://dmas.kepro.org. The requirement for two face-to-face contacts per month between the case manager and the child remains. One of the contacts must be in the foster home. Additionally, one of the contacts shall include the child and at least one foster parent. The child must also be interviewed privately at least once a month.

Non-Covered Services

Services such as counseling, direct treatment, assessment of the adoption placement, foster parent training, and completion of documentation required by foster care cannot be paid by Medicaid, effective March 1, 2007. These services provided by the TFC-CM provider that are not included as allowable payments by Medicaid may be billed to the Comprehensive Services Act (CSA). The services reimbursed by CSA must be distinctly different from those allowed under the new definition of Medicaid Treatment Foster Care Case Management to avoid duplication of services and payment. These payments will continue to be negotiated with the provider and approved by the Community Policy and Management Team. The Office of Comprehensive Services will be providing guidance on treatment foster care services that may be billed to CSA. The OCS website is www.csa.state.va.us.

For services rendered on or after March 1, 2007, providers must bill the new monthly rate. Also effective on March 1, 2007, providers will no longer be required to submit the rate sheet with the claim for dates of service after February 28, 2007, but the provider must keep the previous rate sheets

in the child's record to verify that the locality has agreed to the rate. Prior authorization by KePRO will continue to be required for Treatment Foster Care Case Management reimbursed by Medicaid.

For CSA reporting, the provider must indicate the responsible locality on the KePRO initial and subsequent review fax forms. The fax request forms will be updated to reflect this change and will be available from the KePRO website (https://dmas.kepro.org). Effective March 1, 2007, newly submitted prior authorizations will be eligible for approval for up to one year.